



**North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Michael Moseley, Director

November 21, 2005

MEMORANDUM

TO: Area Directors

FROM: Mike Moseley 

SUBJECT: Information on Partnerships/Alliances/Cooperative Arrangements

The purpose of this communication is to outline the process by which Local Management Entities (LMEs) are to notify the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of their choice of partners in accordance with the Department of Health and Human Services LME Cost Efficiency Proposal (see attached). As you know, DHHS initially suggested specific combinations of LMEs to create ten regions. The regional approach is designed to achieve economies of scale in the performance of utilization review (UR) and screening, triage and referral (STR) functions.. In response to feedback from the North Carolina Council of Community Programs and the North Carolina Association of County Commissioners, Secretary Carmen Hooker Odom modified the plan to give LMEs the opportunity to propose regions, alliances, partnerships or other groupings for this purpose by December 15, 2005.

Letters of intent to partner for the provision of UR and STR functions should be submitted to Dick Oliver, LME Team Leader, by December 15, 2005. Letters must be signed by every Director and Board Chair of the LMEs proposing to participate in a given partnership/alliance/cooperative. Signed letters will be accepted via facsimile. The address is:

Dick Oliver, LME Team Leader
3015 Mail Service Center
Raleigh, NC 27699-3015

FAX: 919/715-1232

On December 15, 2005 the Division will publish a Request for Applications (RFA) for LMEs wishing to serve as the LME performing UR and STR for their partnership area. All LMEs will be eligible to submit an application; the DHHS will select the LME in each partnership/alliance/group/region based upon demonstrated capacity, competency and price.

Please contact your LME Liaison or Dick Oliver at Dick.Oliver@ncmail.net or 919/715/1294, if you have any questions.

cc: Secretary Carmen Hooker Odom
Allen Dobson, MD
DMHDDSAS Executive Leadership Team
Carol Duncan Clayton
Patrice Roesler
Kory Goldsmith

Chair, Coalition 2001
Chair, Commission on MH/DD/SAS
Chair, State CFAC





North Carolina Department of Health and Human Services

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

LME Cost Efficiency Proposal

1. Background

- a) Reform legislation enacted by the General Assembly envisioned no more than 20 LMEs by 2007. Legislation also gave counties authority to determine governance structure.
 - i. When reform began there were 40 Area Authorities. Four years later, there are now 30 with only one additional merger under active discussion. It is not reasonable to assume that goal of 20 will be achieved in the next two years through voluntary mergers. DHHS also believes that the merger of separate organizations can only be successful when they are voluntary.
- b) The LME cost model is a valid tool for projecting the cost of LME functions; but the cost model was built assuming no more than 20 LMEs.
- c) The LME cost model includes some LME functions that may be best administered at a local level to ensure responsiveness to community needs and others that can be performed more efficiently and effectively in a regional or grouped model which delivers economies of scale, with no negative impact on consumers and communities. For example:
 - i. Local: Provider Relations; Consumer Rights and Provider Complaints; Care Coordination; Community Collaboration
 - ii. Regional: Utilization Review, including appeals of UR Decisions; After-Hours Access, Screening, Triage & Referral
- d) The public mental health, developmental disabilities, and substance abuse services system needs additional funding for services. In advocating for additional funding, DHHS must be able to assure decision-makers that funds are not being spent needlessly on inefficient, duplicative administrative costs.
- e) In addition to limited financial resources, we are also faced with finite human resources. It also does not make sense to have excessive numbers of highly trained clinicians performing redundant administrative functions when they are needed to deliver needed services to consumers.

2. LME Cost Efficiency Proposal as Revised Based upon Feedback from NC Council of Community Programs and NC Association of County Commissioners

- a) DHHS has requested that the Council and the County Commissioners Association propose regions, alliances, partnerships or other groupings of LMEs by December 15, 2005 (8 weeks). If the Council and County Commissioners Association are unable to agree on groupings, DHHS will assign LMEs to groups.
- b) DHHS will issue a Request for Proposal by December 15, 2005 to select one LME in each grouping to perform UR and after-hours access and referral functions for the entire group.
- c) DHHS, in collaboration with the Council and County Commissioners Association, will select "Lead LMEs" based upon demonstrated competency and price, by January 30, 2006.
- d) DHHS will perform a thorough analysis of all cost model functions to identify additional opportunities for efficiency. The Council and County Commissioners Association have also agreed to perform a functional analysis in collaboration with DHHS of all LME functions to identify any other functions that can be performed more efficiently and effectively at a statewide or grouped LME level by March 31, 2006. Any efficiencies identified by these analyses will be implemented July 1, 2006.
- e) By April 1, 2006 Lead LMEs will have UR for all Medicaid services operational for all LMEs in their group. [Note: LMEs will not perform UR for inpatient services, PRTF, and out-of-state Medicaid services, all of which will be performed by a statewide vendor. In addition, the statewide vendor will perform quality assurance reviews on LMEs' UR performance.]



- f) By June 1, 2006 Lead LMEs will have after-hours access, screening, triage and referral functions operational for all LMEs in their group.
- g) By May 31, 2006 all LMEs will have determined the benefit design for state and federal funded (non-Medicaid) services in their catchment area and will have summarized this information in a format that can be easily communicated to and administered by the Lead LME.
- h) By July 1, 2006 Lead LMEs will have UR for state funded services operational for all LMEs in their group.
- i) DHHS will work with the Council and the County Commissioners Association to explore options for Area Authorities to be public service providers and not LMEs. An outline of possible options to accomplish this must be completed by April 1, 2006.

3. **The Money**

- a) DHHS fully funds the LME cost model. There are no county funds required to pay for LME functions.
- b) We anticipate that the DHHS and DHHS/Council/Commissioner Association analyses will identify changes to the cost model that will result in lower administrative cost. While we have not presumed any specific dollar target for these cost savings, the administrative funding budget will be adjusted to reflect the revised projected cost of LME administrative functions. If additional funds are needed to fully fund LME administrative cost on a recurring basis after all potential cost efficiencies are identified and implemented, the Department will request expansion funds.
- c) For SFY 2006, allocations for UR and after-hours access and referral will be reduced to all but the Lead LMEs following the selection of Lead LMEs.

